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CARE IN THE COMMUNITY

A CONSULTATIVE DOCUMENT ON MOVING RESOURCES FOR CARE IN ENGLAND

Department of Health and Social Security

July 1981

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CONTENTS

		Page
Section 1	INTRODUCTION	1
Section 2	BACKGROUND	1
Section 3	THE SIZE AND NATURE OF THE PROBLEM	2
	Mentally Handicapped People	2
	Mentally Ill People	2
	Elderly People	2
	Financial Implications	3
	Staffing Implications	4
Section 4	COLLABORATION BETWEEN NHS AND PERSONAL SOCIAL SERVICES	4
Section 5	JOINT FINANCE	5
Section 6	SUGGESTIONS	6
	Extension of Joint Finance Arrangements	7
	Lump Sum or Annual Payment	7
	Transfer of Hospital Buildings	8
	Pooling Funds for a Client Group	9
	Central Transfer of Funds	10
	Earmarking NHS Funds	11
	Concentrating Responsibility for a Client Group	11
Section 7	GENERAL	12
Section 8	ACTION	13
Annex A	THE EXISTING STATUTORY PROVISIONS	14
Annex B	SOCIAL SECURITY	16
Annex C	ORGANISATIONS TO WHOM THE DOCUMENT IS BEING SENT	18

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INTRODUCTION

1.1 Most people who need long-term care can and should be looked after in the community. This is what most of them want for themselves and what those responsible for their care believe to be best.

1.2 There are many people in hospital who would not need to be there if appropriate community services were available. But the legal, administrative and financial framework within which health and local authorities operate presents obstacles to their transfer. This consultative document sets out a number of suggestions for ways in which the obstacles might be overcome and seeks the views of interested parties on them. The Department would also welcome other constructive suggestions for overcoming the problem.

BACKGROUND

2.1 A great deal has already been done to enable more people to be cared for outside hospital, but more could be done if resources of money and manpower were available. In the longer term a further shift in the balance of resources from hospital to the community services is desirable. This policy is emphasised in Care in Action*. Strengthened primary and community care services will help elderly people to live independently in their own homes; services for those who are mentally ill, including in some cases residential, day care and other support, will enable them to keep in touch with their normal lives; and services for mentally handicapped people will enable them to live with their families, or failing that in a supportive local community setting. Such services require the co-operation of neighbourhood and voluntary support, primary health care services and personal social services.

2.2 Transfer from hospital to community health care does not require special financial mechanisms because health authorities can make appropriate adjustments within their own budgets, though there are difficulties of other kinds particularly in relation to the redeployment and training of suitable staff. More serious problems arise in transferring resources to enable social services departments - part of local government - to take responsibility for people at present in hospitals - for which the NHS has responsibility. Increased expenditure over the last decade or so has enabled social services departments to expand their activities considerably, and joint finance has further increased the resources available to both the statutory and voluntary services and has stimulated joint planning. However, more social services provision is needed, both to keep up with the rising numbers of very elderly people and to provide for those being cared for in hospitals who might be better cared for in the community. Reducing long-stay hospital accommodation without expanding alternative provision is not the answer.

2.3 The suggestions made later in this document would require positive collaboration between health and local authorities. Existing joint planning mechanisms would remain and the present joint finance scheme would, except under the arrangements set out under Suggestion 1 below, continue in substantially its present form. The suggestions would have to be implemented within planned resources. Progress depends on making better use of

* DHSS. Care in Action: A Handbook of Policies and Priorities for the Health and Personal Social Services in England. HMSO. 1981.

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what is already available, including the important contribution of the voluntary and private sectors. Many who are now in their own or in community homes would also benefit from development of these services, while some would in fact probably be better cared for if they could be transferred into hospital in place of some who need not be there.

2.4 The discussion in this document is mainly in terms of the needs of elderly, mentally ill and mentally handicapped people, but there are other, smaller groups, such as those who are physically disabled or chronically sick, who could be expected to benefit from arrangements which encourage the transfer of people in hospital to the care of social services departments. The suggestions set out below should be judged against the circumstances of both client group and locality. It may be that a combination of the mechanisms suggested would be helpful and it is certainly unlikely that any single suggestion would meet all needs. Joint assessment between health and personal social services will be needed before decisions about individuals are taken.

THE SIZE AND NATURE OF THE PROBLEM

Mentally handicapped people

3.1 As a beginning it is estimated that about 15,000 mentally handicapped people at present in hospital - about one third of the total number - could be discharged immediately if appropriate services in the community were available. Their needs for support are unlikely to change and once discharged into social services care they would probably not have to return to hospital.

Mentally ill people

3.2 Nearly all seriously mentally ill people need help from both the NHS and the personal social services and collaboration between the two is particularly important for them. Most people discharged from hospital psychiatric care have had only a short period as in-patients and do not need long-term help after leaving. Other people have spent many years in hospital and could no longer live outside it. There may, however, be up to 5,000 people now in hospital who fall in between these two groups and may be capable of leading more independent lives. Some would not be best placed in local authority residential care but might need a local authority day centre. It will be important to develop personal social services to meet this need as part of the pattern of integrated, district based services. This will require the development of health as well as social services. There may also be scope for new approaches to the care of elderly severely mentally infirm people now in hospital.

Elderly people

3.3 It is often not possible to make a once and for all assessment of the long-term needs of an elderly person. Some of those discharged from hospital will return later, sometimes for good. While there are differences of opinion about the scope for discharging long-stay patients from hospitals to the care of social services, there are elderly people in hospitals who do not need to be there. The objective of enabling elderly people to live as far as possible in the community requires the development not only of personal social services but also of primary health care services and of acute geriatric services. The patterns of health and social services provision and the interactions between the different forms

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vary greatly according to local conditions and these variations make it impossible to provide overall figures for the numbers of elderly people who might suitably move one way or the other.

Financial Implications

3.4 There are obvious difficulties in quantifying the financial implications of transferring people from hospital to community care. Some indication of the scale of resources involved may be gleaned from the health service costing returns which show that the annual cost to the NHS of caring for 15,000 mentally handicapped hospital patients was about £90 million in 1979/80, or on average £6,000 per patient. The cost of caring for 5,000 patients in mental illness hospitals was around £35 million, an average of £7,000 per patient. No estimate is available of the numbers of elderly people in geriatric hospitals who might be more suitably cared for by the personal social services but each patient cost the NHS on average about £8,000 in 1979/80.

3.5 If all mentally handicapped and mentally ill patients who could benefit from community care were transferred to the care of local authorities, the total cost falling on social services departments would, on the basis of the calculations set out above, be about £125 million a year, an average of £1.2 million annually for each social services department. About 160 to 170 mentally handicapped people, and up to 50 to 60 mentally ill people, would on average be involved in each social services department area. However, no provision for elderly people transferred from hospital is included in these figures.

3.6 These figures are included purely for illustrative purposes to give some idea of scale and should not be taken as considered estimates. In practice the people who would be transferred would be likely to be the less heavily dependent, costing less than the average in hospital. As a result the average cost per hospital patient remaining would increase. Health authorities would also need to continue to provide health services for people transferred (eg community psychiatric nursing and primary health care services).

3.7 Although the cost to the community health and personal social services of providing care for people transferred from hospital is difficult to assess, there are good reasons for believing that in many cases it would both be lower and better value. It would depend, for example, on whether new hostels are built, existing hospital property transferred and adapted, or surplus local authority accommodation brought into use. Hostel places for mentally handicapped adults cost about £2,500 a year for each client (net of charges to clients). The cost of day centre provision is £1,200 per place, but assuming that only half of those transferred attend a day centre the average cost per person transferred would be £600. These figures suggest a considerable saving but account must be taken of capital expenditure and other costs such as transport and administration. On the other hand, it is easier to harness the energy and resources of the voluntary sector if people are in the community, rather than in hospitals. Such transfers might also enable the NHS to release capital tied up in land and buildings.

3.8 The cost of social security payments made to a person outside hospital is higher than those made to someone in hospital, the money being used either to help the individual to live independently in the community or to

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help meet the costs of the authority providing residential care. This document does not examine social security aspects in detail but a broad description of the position is given in Annex B.

Staffing Implications

3.9 Any arrangement which involves transferring people from one statutory authority to another may have implications for staff. The transfer of people from hospital to the care of the personal social services may involve an expansion in residential and other local government services and in health services outside hospital, and a reduction in hospital provision. The staffing implications would depend on the arrangements made - for example the extent to which health services staff continue to provide care for those transferred, and the role of voluntary organisations. Where extra local authority staff were employed as a result of implementing the suggestions made in this document, it would be made clear that under most options their employment was not funded from relevant expenditure for rate support grant. It will clearly be important that health and local authority workers should be fully committed to the success of projects arising from the suggestions made in this document, and proposals would need to be preceded by full consultation with local staff interests.

COLLABORATION BETWEEN NHS AND PERSONAL SOCIAL SERVICES

4.1 The importance of the joint planning of health and personal social services was recognised during the 1974 reorganisation of the NHS. The Report of the Working Party on Collaboration led to the statutory obligation on health and local authorities to collaborate and to set up joint consultative committees (JCCs), and dealt with the provision of goods and services and the sharing of certain professional staff. Social services departments were to be involved as necessary in the planning of NHS services. The Working Party also considered the possibility of giving JCCs control over the expenditure of health and local authorities in matters of joint concern and powers to plan in their own right, but concluded that this would disregard constitutional realities and interfere with clearly defined management responsibility on both sides, and would be an obstacle to progress.

4.2 Section 22 of the 1977 NHS Act provides for the establishment of JCCs. They have the duty of advising their respective authorities on key services and client groups for which joint planning is desirable, and to make recommendations on priorities for joint planning. There is provision for the establishment of joint care planning teams to work under the guidance of the JCC.

4.3 Although JCCs and joint care planning teams exist in most areas, their effectiveness varies. Both bodies can only advise, and their influence depends on the commitment of the health and local authority to joint planning. They are sometimes seen as urging the development of local authority social services in ways which will ease the burden on the NHS without providing commensurate benefits for the local authority. It has also been suggested that joint planning has been inhibited by the failure of staff of different authorities to understand the difficulties and different circumstances of their opposite numbers. But perhaps the most consistent problem experienced has been lack of local authority finance to carry forward schemes jointly planned.

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4.4 The establishment of district health authorities will require increased effort by health and local authorities to achieve effective collaboration. The statutory provisions will permit the establishment of one JCC covering two or more district health authorities within the area of a local authority, though precise arrangements will be for decision by the authorities concerned.

JOINT FINANCE

5.1 The Department introduced joint finance in 1976 to enable NHS funds to be used for collaborative projects primarily in the personal social services field for the better care of patients. Both local authorities and voluntary bodies sponsored by them can receive funds. The scheme has helped to develop joint planning and bring about closer collaboration between health and local authorities and voluntary bodies, and has made a significant contribution to transferring care to the community. Allocations earmarked for joint finance have risen from £16.4 million in 1976/77 to £68.5 million in 1981/82 and a further increase to £71 million is planned for 1982/83 (November 1980 prices). About 40% of this money has been spent on services for the elderly and about 33% on services for the mentally handicapped. Joint finance does not count as 'relevant expenditure' for rate support grant purposes.

5.2 As joint finance has developed, it has been made more flexible. All capital costs of a scheme may now be met and all revenue costs for up to three years. Revenue costs can be met from NHS funds on a reducing scale (tapering) for up to a further four years, or longer with the approval of the Secretary of State. Both primary health and community care schemes are covered. It is, however, a fundamental principle of the scheme that responsibility for the revenue consequences of social services provision should in due course pass to the social services department or voluntary organisation.

5.3 By a careful blend of projects, including capital schemes (where the use of joint finance saves local authorities having to incur loan charges) and short term projects, many local authorities have made good use of joint finance, often improving services in imaginative ways, with manageable long-term revenue consequences. In other places, the combined effect of the build up of joint finance projects incurring long-term revenue consequences, and current financial constraints, has led to authorities becoming increasingly reluctant to agree to schemes for which they will eventually be required to assume full financial responsibility.

5.4 The main limitations which local authorities see in existing joint finance arrangements are:-

a. jointly financed schemes entail a commitment to future revenue costs, through the tapering of the NHS contribution, when the resources likely to be available to social services departments are uncertain;

b. joint finance provides no guaranteed source of funds for major extensions of personal social services: decisions are made on individual schemes and when one ends it may not be replaced by another;

c. joint finance does not extend to the local authority's housing and education responsibilities, though these may be involved when people are transferred from hospital to the care of the social services department;

d. joint finance may limit the freedom of Councillors to set their own relative priorities between services and take their rating decisions within the overall framework of the Government's expenditure plans and the unhypothecated block grant system.

SUGGESTIONS

6.1 A number of health and personal social services authorities have already been considering ways of enabling people to be transferred from hospitals to hostels or houses nearer their own homes as a first step towards independence. These ideas include:-

a. the health authorities selling hospital sites and donating the proceeds to the local authority for the development of smaller, residential facilities near patients' homes;

b. the development of a "single service partnership" for services for the mentally handicapped and the pooling of health and local authority funds to finance it;

c. the conversion of local authority premises into hostels to accommodate people inappropriately cared for in hospital, with the local authority staffing and running the hostel and the health authority meeting the cost on a contractual basis and being responsible for selecting the people to be transferred;

d. the sale of a NHS TB hostel to a housing association, the health authority continuing to pay for people using the hostel;

e. converting hospital "villas" to hostels which the residents rent from the health authority, using their supplementary benefits to pay for food and accommodation.

There is no lack of interest in finding ways round existing problems, but other pressures on personal social services resources, and obstacles, legal and otherwise, to the transfer of NHS resources, are holding up progress in many cases.

6.2 The rest of this section examines various ways of encouraging the transfer of patients from hospital to the care of social services departments. Some of them would require legislation, the precise nature of which would depend on the methods chosen. The immediate task is to consider how best to achieve the objective, and this document does not, therefore, examine the legislative implications in detail. Existing relevant legislation is outlined in Annex A.

6.3 The suggestions made below fall broadly into four categories which are not mutually exclusive:-

a. removing barriers to local arrangements for transferring patients and resources from the NHS to the personal social services;

b. promoting closer co-operation between health and local authorities and advancing joint planning;

c. transferring funds centrally from the NHS to the personal social services; and

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d. concentrating responsibility for a client group on a single agency.

6.4 In any of these cases a local authority might arrange for some or all of the services to be provided by a voluntary organisation acting on its behalf. Alternatively, a health authority might, in collaboration with the local authority, make arrangements direct with a voluntary organisation to provide care for individuals or groups of people.

Local arrangements for transferring patients, funds, etc.

6.5 Suggestion 1 - extension of joint finance arrangements - section 5 drew attention to the present limitations of the joint finance scheme. However, it would be possible to amend and extend present arrangements. For example, an important obstacle in some cases appears to be the present tapering provisions. The relaxation or abolition of a maximum period for 100% joint finance of the revenue costs of a scheme (at present 3 years) might encourage local authorities to undertake longer term projects. The main features of such a scheme might be:-

a. 100% joint financing for 10 years with tapering over a further 5;

b. NHS funds for joint finance could be drawn either from health authorities' own resources, at their discretion, or from an increase in the sums earmarked in allocations;

c. savings to the NHS resulting from the transfer of patients could be channelled into new joint projects;

d. control would be exercised by the JCC as at present;

e. existing joint finance agreements would stand.

6.6 A scheme of this kind would build on existing arrangements. Decisions both on the total of NHS funds committed and their use would be taken locally. However, the suggestion involves changing the nature of the joint finance scheme and perhaps losing some of its advantages in the process. It could be modified by preserving the present arrangements for a proportion of the joint finance allocation. The method of allocating joint finance to health authorities may need to be reviewed in any event as a consequence of NHS restructuring.

6.7 Suggestion 2 - lump sum or annual payment - the health authority might pay the local authority a lump sum, or give a guarantee of annual payments, for each person discharged into the local authority's care. The method of calculating the payment would need careful consideration, but it might be based on, for example, the average cost to the personal social services of caring for the client group in question over a period. Adjustments might need to be made in the light of experience. Some of the people transferred would become less dependent as time went on, others more, and some might have to return to hospital. Because of these uncertainties it might be preferable, at any rate after an initial period, for the health authority to fund places rather than individual patients. As the people transferred initially from hospital vacated the hostel places others would be selected by the health authority to take their place.

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6.8 This suggestion envisages the long-term support of personal social services provision from NHS funds, but only insofar as the need for health services was correspondingly reduced. There would be no net increase in the total provision of services. The sums transferred would be income to the local authority rate funds, and need not add to relevant or total expenditure for calculating or distributing rate support grant.

6.9 A scheme of this kind would have a number of advantages:-

a. there would be a direct relationship between the number of patients cared for and the NHS funds available;

b. health authority funding would not need to be confined to places in a particular local authority: in the case of a large mental hospital with a wide catchment area it might be found convenient to fund places in several local authority areas (because the NHS would be paying, the question which local authority was the originating authority would be less important);

c. arrangements could be developed gradually and locally, taking account of the needs of the people concerned and the facilities available. Funds for transfer could be related to savings achieved through emptying hospital beds (though there might be a need for an initial injection of capital, for example to build hostels and residential homes);

d. joint finance could be used to inject extra capital or revenue if needed.

6.10 The key feature of this approach is flexibility. It could be started on a small scale and developed in the light of experience. A scheme on these lines is to be tried in Warwickshire. There, agreement has been reached in principle for the Social Services Department to act as agent for the Area Health Authority in providing a hostel with 20 places. Although the hostel will be run solely by the local authority, nomination for places will be entirely in the hands of the Health Service, either for patients inappropriately in hospital or patients in the community who would otherwise have to go into hospital. The costs of the hostel, about £100 a week for each place, will be met by the Health Service together with about £40 a week for each hostel resident who needs a place in an Adult Training Centre.

6.11 The pilot scheme is planned to begin in the autumn of this year in a building which is otherwise surplus to the local authority's requirements. If it is successful more hostels could be established along similar lines, but in any case it is written into the contract that the Area Health Authority would give a year's notice to end the agency agreement. Savings will be available to the Health Service when it will be possible to close a hospital ward, but it may also be possible to avoid capital work which would otherwise be necessary.

6.12 Suggestion 3 - transfer of hospital buildings - an alternative to the gradual transfer of people from hospital to local authority care might be the transfer of ownership of a hospital (see paragraph 6.15) and responsibility for people who no longer needed hospital care. NHS funds earmarked for hospital development or improvement and running costs would probably also be needed to support the transfer, though the health authority would still need to provide also for those who remained in its care.

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6.13 Such a scheme could effect the rapid transfer of all the in-patients of a hospital who no longer needed hospital care, together with their accommodation, and place in the hands of a single authority the task of providing the most suitable accommodation and care. It would, however, depend on the availability and suitability of hospital accommodation for this purpose: specialist units for mentally ill or mentally handicapped people might be candidates.

6.14 Under Government accounting rules the gift of the freehold or lease of hospital buildings and land requires the consent of the Treasury and, for more valuable property, laying an Order before Parliament. Some empty, surplus NHS buildings have been leased to local authorities, the rent being met from joint finance funds initially, and their use being restricted to health and personal social services purposes. Any lease must be at a rental set by the District Valuer, but could be capitalised and paid off in a lump sum, again using joint finance. The local authority has the option to purchase at current market value during the term of the lease. So where it was intended that a property should remain in NHS ownership at least for the time being leasing arrangements could apply. If, however, it was decided to sell the building to the local authority, joint finance could be used to help the local authority to make the purchase as an inducement to take over responsibility for both building and patients.

6.15 Some hospitals may be suitably placed for eventual use for other health or local authority purposes. But many hospitals, including we believe some thirty out of a hundred large mental illness hospitals, are not well placed to provide a local service. As "Care in Action" said (paragraph 5.9(c)) closure of these hospitals should provide a source of staff, capital and revenue to support the development of the new pattern of health and perhaps local authority services. Where such hospitals are on valuable sites one option which has been canvassed is to sell the property in advance of closure, and then lease it back so that the proceeds of sale could be used to assist the provision of alternative more cost-effective services. If this proves to be a practicable proposition it deserves to be carefully considered.

6.16 This and other suggestions carry implications for community health services which would be carrying some of the responsibility that previously fell on hospital staff. This would need to be borne in mind in calculation of costs and assessment of possibilities.

Promoting closer co-operation between NHS and PSS

6.17 Suggestion 4 - pooling funds for a client group - health and personal social services authorities might pool the funds they each had available for a particular client group and plan services jointly. Day to day management of premises and staff might be left undisturbed. Pooled funds might be administered by a joint committee, possibly the joint consultative committee, having planning and management powers delegated by the authorities concerned and responsible to them, and building on the work of joint care planning teams. Whether a committee at least partly non-elected should have powers of precept, the extent of its autonomy and the pooling of assets as well as funds raise complex and far-reaching issues. And a joint programme for a client group would clearly need to fit with the wider plans of health and local authorities.

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6.18 Such an approach would aim directly at a key objective - using resources available for a client group to best advantage. It should be possible, for example, to run down hospitals for mentally handicapped people and build up community services in accordance with a detailed development programme. Voluntary bodies and housing and education interests would need to be consulted as part of such joint planning arrangements.

6.19 Problems of conflicting health and local authority priorities would have to be faced and the question of how much each would contribute would need to be resolved. These difficulties would be compounded where health and local authority boundaries were not coterminous.

6.20 In principle this suggestion could apply to any client group. It could be combined with any other suggestion for transferring people and resources. To that extent the financial implications of the other suggestion would apply.

Transferring funds centrally or regionally

6.21 Suggestion 5 - central transfer of funds - in principle, funds could be transferred from the NHS to local government by an adjustment at national level in public expenditure plans. Under such an arrangement personal social services relevant expenditure would be increased and the allocation of funds to the NHS decreased, but this would need to be considered in the wider context of the Government's policies for sustained reductions in overall local government expenditure. The transfer would have to proceed incrementally over a period long enough to enable personal social services provision to be built up and NHS services to be reduced. Since no immediate reduction in NHS services could be achieved, the sums transferred each year might need to be taken from whatever growth money was available to the NHS for these services.

6.22 There would need to be a clear indication of what the funds transferred would be used for. Local authorities have not, in the past, welcomed earmarking of funds allocated to them, and the present arrangements for their capital expenditure control and revenue finance avoid this as far as possible. Moreover such earmarking might be difficult to monitor without considerable bureaucratic intervention and would run counter to the present unhypothecated approach to RSG, and the Government's present request for reductions in the totals of local authorities' spending. Suitable provision would also need to be made in local authorities' capital allocations, though they remain free to switch in the light of local judgements about relative priorities. If, on the other hand, sums were not earmarked there would be no guarantee that they would be devoted to development of the personal social services: the money might simply be lost in local authority budgets without clear benefit emerging for the patients concerned.

6.23 The scale and character of transfers of patients and resources needed between the health and social services vary widely between different localities. The suggestions in this document concentrate on mechanisms which would encourage individual health and local authorities to agree on local priorities and then to take action that suited their own circumstances. This suggests that central transfers of funds would be appropriate only in relation to the complete transfer of responsibility for a client group to a single agency - Suggestion 7 below.

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6.24 Suggestion 6 - earmarking NHS funds - an alternative to central transfer of funds from the NHS to local authorities would be for NHS funds to be retained centrally or regionally to be drawn upon to help social services departments build up their services and take over NHS patients. Funds could be used for either capital or revenue and might be allocated in respect of specific, costed and approved local developments possibly jointly administered by health and local authorities. This avoids the difficulty seen in Suggestion 5 of funds not reaching the places where they are needed.

6.25 Such a scheme would also deal with the problem of transitional costs where the savings to the NHS, which may not be significant until a hospital can be closed, do not match the local authority outlay. It could supplement the "bridging loan" systems already operated by some RHAs. It would be difficult to judge what sum should be reserved for this purpose, but the scheme, if successful, could be developed gradually as resources were available. There would be administration problems to be resolved. It would be difficult for the Department to administer arrangements involving each social services department, and an administering agency would probably have to be set up which included representatives of health and local authorities to which local authorities would apply with specific projects. If administration at regional level were preferred, a regional JCC might be established representative of local JCCs. Whatever approach were adopted the administrative costs might be considerable.

6.26 An added incentive to local government to apply NHS funds available under this suggestion to measures for transferring hospital patients to community care might be to make it a condition that the local authorities should take over, within an agreed period commensurate with the resources available, those people who should not be in hospital.

Single agency for a client group

6.27 Suggestion 7 - concentrating responsibility for a client group - This idea, which has been floated in the past, involves making one authority, either health or local, responsible for a client group. For example, a social services department might be given responsibility for providing services for all mentally handicapped people in its area (the suggestion most often made, though in principle similar arrangements might apply for other groups). The advantage of such a scheme is that responsibilities would be clear and, in the example given, the local authority would have incentive to move mentally handicapped people out of expensive hospital accommodation. Those who remained in hospital might be paid for on a contractual basis by the local authority. This suggestion goes further than Suggestion 3 but similar issues concerning transfer of premises and finance would arise.

6.28 While such a scheme has some attractions in the case of services for mentally handicapped people, it is difficult to see how it could be made to work in the case of less clearly defined groups such as elderly or mentally ill people. Even with a relatively well defined client group there would be room for argument over marginal cases. The idea was one of those considered and rejected by the Royal Commission on the NHS.

6.29 The establishment of a single central authority at national level with concern for all services for a client group has also been suggested in relation to mental handicap. Such a body might act as a pressure group, but would have to work through health and local authorities. It could be strengthened by an allocation of funds to be used for transferring people

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from hospital to community care. However, problems of conflicting priorities at national level would arise, as they arise now, and it would be difficult to defend the establishment of such a body for one client group but not for others.

6.30 These variations of Suggestion 7 raise policy issues beyond the scope of this document, but they are included for completeness. If comments indicate substantial support in principle for either approach a much more detailed examination would be needed.

GENERAL

7.1 These general points are important:-

First, the primary aim is a service in settings more appropriate to the needs of individuals being cared for. Any proposed change should carry reasonable assurance that this aim will be achieved more quickly than under present arrangements.

Second, a scheme should contain some incentive for both health authorities and local government.

Third, there will be a need for adequate assurance that any NHS funds transferred to build up the personal social services are used for that purpose, given the overall framework of the Government's policies for the totals of local government expenditure and manpower, and the need to ensure that the NHS is relieved of responsibility to an extent commensurate with the resources transferred.

Fourth, proposals which depend for success on the injection of large amounts of extra funds are unlikely to be implemented quickly since the funds would have to come from existing total resources.

Fifth, the practical steps towards achieving the transfer of patients and resources will need to be worked out by the district health authorities and the corresponding local authorities in close co-operation, taking account of local facilities and opportunities and the contribution that the voluntary and private sectors can make.

Sixth, if we are more successful in maintaining people in the community the present requirements for facilities for long-stay hospital patients will not always be identical with likely future needs. Decisions about the next 10 years may therefore have to be made with longer-term requirements in mind.

7.2 Caring for ex-hospital patients in the community may involve not only the health and personal social services but also housing and education services. Housing and education authorities would therefore need to be involved at an early stage in discussions about any schemes which had implications for them. The present statutory powers for NHS authorities to make grants to local authorities do not extend beyond grants for personal social services provision, and funds voted by Parliament for health purposes may not be diverted for housing or education purposes. It is not clear whether and to what extent the lack of such powers would present an obstacle to reshaping services to meet needs, for example in relation to education facilities at present provided in hospitals for mentally handicapped people.

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Close liaison with the local social security office would be required to ensure payment of appropriate social security benefits at the right time to those clients being transferred out of hospital.

7.3 Care of elderly and mentally ill people requires a range of services from specialist hospital care through residential and day care to support in the home. Smaller NHS units, nearer to home and family, would be more appropriate than hospital for many people, while others at present in residential homes would benefit from the provision of more very sheltered housing. Those local authority residential units which are too large to be ideal as residential homes could be purchased by health authorities for use as NHS units and the funds transferred to the local authority in this way could be used to develop alternative provision. Some of the mechanisms explored in this document could assist the process.

7.4 The suggestions in this document, particularly those involving local rather than national transfer of resources, would be used in different ways in different localities, to reflect local priorities and existing services. However, most of the suggestions involve breaking new ground in the joint arrangements between health and local authorities and there might be advantage in concentrating first on groups of people whose needs for care are most easily predictable. On this basis the mentally handicapped might often be the group that many authorities would wish to consider first.

ACTION

8.1 Authorities wishing to proceed with local experiments within the present statutory framework are encouraged to do so. Experience gained in this way should prove valuable to the authorities concerned, to other authorities and to the Department in considering the directions in which further progress can best be made. The Department would be glad to know of any schemes in progress or planned, or rejected because the present statutory framework would not permit them.

8.2 Comments will be welcomed on all the suggestions set out in this document and on the other issues raised. Any additional suggestions for overcoming the problems identified will also be welcome. They should be sent no later than 30 November 1981 to DHSS Planning and Prevention Division Branch 3, D412, Alexander Fleming House, Elephant and Castle, LONDON SE1 6BY Tel 01-407 5522 Ext 7874 or 6891. A list of organisations to whom the document is being sent is at Annex C.

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THE EXISTING STATUTORY PROVISIONS

1. The provisions briefly described in this annex are relevant to the issues in the consultative document.

2. NHS Act 1977 Section 21 (2) permits a local social services authority providing premises for any of the purposes of the Act to allow the use of those premises by any body constituted under the Act on agreed terms including the services of staff. This would allow health authorities to pay for local authority premises, services and staff for use for health service purposes.

3. NHS Act 1977 Section 23 allows the Secretary of State to arrange for any person or body to provide services under the Act and for him to provide facilities and staff, subject to agreed terms.

4. NHS Act 1977 Section 26 requires the Secretary of State to make services, facilities and staff available to local authorities so far as is reasonably necessary and practicable to enable them to discharge their functions relating to social services, education and public health.

5. NHS Act 1977 Section 27 prescribes conditions regarding Section 26, including consultation with NHS officers so made available and agreement on terms including charges.

6. By virtue of the NHS Functions (Direction to Authorities Regulations) 1974, in particular regulations 3(3)(q) and 5 and 5(1) the Secretary of State's functions are exercisable by Regional and Area Health Authorities.

7. NHS Act 1977 Section 28 A, inserted by the Health Service Act 1980 Section 4, permits AHAs and DHAs to make grants to local social services authorities in relation to their functions under section 2(1) or (2) of the LASS Act 1970 and to district councils in relation to their functions under section 8 of the Residential Homes Act 1980 (meals and recreation for old people) and to voluntary organisations. Provision is made for Secretary of State to prescribe conditions, but no time limits on grants are imposed by the Act. This is the statutory basis for the joint finance scheme. Detailed information on the operation of this scheme is given in HC(77)17/LAC(77)10; Dear Administrator Letter dated 20.3.1978 and HC(79)18/LAC(79)11.

GENERAL COMMENT

8. The consultative document does not deal in detail with legislative implications. In general it appears to the Department that at present:-

a. there are no powers to set up joint health authority/local authority committees with executive functions, or to contribute joint finance to such committees;

b. the only powers to use NHS funds to finance personal social services are the joint finance provisions in section 28A of the 1977 Act as inserted by the 1980 Act;

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c. the transfer of NHS facilities to local authorities as going concerns might need legislation, and the Secretary of State might be open to challenge as breaching his obligation to provide services under section 1 and section 3 of the 1977 Act;

d. the establishment of a central authority to provide all services for a client group, or the transfer of all responsibility to individual local authorities, would be likely to require primary legislation.

9. The legal issues are complex and much would depend on the approach or combination of approaches adopted. Existing legislation was not framed with the need for flexibility between the NHS and the personal social services principally in mind. Depending on the outcome of consultations a review of the legislation might be needed.

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ANNEX B

SOCIAL SECURITY

1. Social security in this country is a matter of payment of cash benefits to or for the benefit of entitled individuals. Contrary to the practice in certain Continental Social Security Schemes, there is no provision for benefits in kind or for services. The national insurance contribution provides some revenue, by a specific element within that contribution, for the National Health Service. Any question of further increasing the resources obtained by this means (they have already been increased from April 1981) or of using the same method to raise money for the personal social services is a matter for discussion in other contexts.

2. Reallocation of social security expenditure to health or social services - a course which is sometimes advocated - is also a matter for discussion in other contexts. It has to be borne in mind that for the most part it has not been possible, at a time of economic stringency, to do more than price protect the levels of benefits; and that at any time when additional resources become available there would inevitably be priorities within the social security programme to consider.

3. The main "traditional" social security benefits are those made in replacement of earnings where earning is temporarily interrupted or permanently ceases: unemployment, short-term and long-term incapacity, retirement and widowhood. In their flat-rate form, the contributory benefits for these contingencies are not greatly different from the means-tested supplementary benefits paid in replacement of earnings. Supplementary benefit in turn is seen as a safety net provision. As maintenance benefits, these benefits are reduced - to an extent varying with the existence of dependants - where a person receives free maintenance in hospital. Payment is continued to those admitted to local authority accommodation, but the local authority charge can be levied against benefits as against other personal income, and the net amount left to the individual beneficiary for personal use reduced accordingly (subject to a prescribed minimum). In the case of the long-term contributory benefits for invalidity, retirement and widowhood, the development of the New Pension Scheme from 1979 onwards means that overall levels of benefit are increasing for new beneficiaries, and the amount available for personal maintenance in the community or for carrying local authority charges increases accordingly.

4. Compensation payments under the Industrial Injuries or War Pensions Schemes and handicap benefits for people disabled in civilian life are in a different category. Compensation payments are not in general reduced during hospital in-patient treatment, and are not fully available for levying local authority charges. Of the two specific handicap benefits introduced during the last decade, Attendance Allowance for severely handicapped people in need of care and attention from others ceases after four weeks of in-patient treatment, on the basis that needs are met by the hospital, and is not paid to those being provided for in local authority accommodation. Mobility allowance on the other hand, which goes to those unable or virtually unable to walk, is paid in full to all those able to benefit from it, whether in hospital, at home or in residential care. This reflects the view that enhanced mobility is a personal need which it is not the specific function of the NHS or the Social Services to meet for the individual.

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5. Neither Attendance Allowance, which is paid to the person in need of care and attention, nor Invalid Care Allowance, which is a non-contributory maintenance benefit for certain people who are caring for others at home, was introduced with a view to encouraging home care. Rather they were designed to provide enhanced financial support for home care where this was being provided. For example, Attendance Allowance at the higher rate appropriate to day and night care/attention would be by no means adequate to pay for the cost of full-time professional attendance; and Invalid Care Allowance, which is set at 60 per cent of the flat-rate retirement pension level, would not be adequate of itself to provide financial support for someone unable to work through being required at home to care for a severely disabled person - where the carer had no additional personal resources. The enhanced range and levels of benefits in recent years has no doubt played a part in the balance of care, but more probably by confirming and underpinning choices made for other reasons than by themselves enabling someone to stay in his own home where otherwise he would have been admitted to hospital or residential care.

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ANNEX C

ORGANISATIONS TO WHOM THE DOCUMENT IS BEING SENT

Addiction Research Unit
Age Concern
Al-Anon
Alcohol Education Centre
Alcoholics Anonymous
Alcoholics Recovery Project
Ambulance Service Institute
Area Health Authorities
Association of British Paediatric Nurses
Association of Chief Administrators of Health Authorities
Association of Chief Ambulance Officers
Association of Chief Chiropody Officers
Association of Child Psychotherapists
Association of Community Health Councils of England and Wales
Association of Community Homes (Schools)
Association of County Councils
Association of Directors of Social Services
Association of District Councils
Association of Domestic Management
Association of Health Sector and Unit Managers
Association of Health Service Personnel Officers
Association of Health Service Treasurers
Association for Improvements in the Maternity Services
Association of Medical Records Officers
Association of Metropolitan Authorities
Association of National Health Supply Officers
Association of Nurse Administrators
Association of Public Service Finance Officers
Association of Residential Communities for the Retarded
Association for Spina Bifida and Hydrocephalus
Association of Sterile Supply Managers
Association of Supervisors of Midwives
Boards of Governors
British Agencies for Fostering and Adoption
British Association of Social Workers
British Association for the Study of Community Dentistry
British Dental Association
British Dental Hygenists Association
British Dietetic Association
British Epilepsy Association
British Geriatrics Society
British Institute of Mental Handicap
British Orthoptic Society
British Red Cross Society
Campaign for the Homeless and Rootless
Campaign for Mentally Handicapped People
Carr-Gomm Society
Catholic Child Welfare Council
Central Council for the Education and Training of Social Workers
Central Midwives Board
Centre on Environment for the Handicapped
Centre for Policy on Ageing
Chartered Institute of Public Finance and Accountancy
Chartered Society of Physiotherapy

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Church Army Residential Services
Church of England Children's Society
College of Occupational Therapists
College of Radiographers
College of Speech Therapists
Common Council of the City of London
Commonwealth Nurses Federation
Community Health Councils
Community Medicine Consultative Committee
Community Service Volunteers
Council for the Education and Training of Health Visitors
Council for Professions Supplementary to Medicine
Counsel and Care for the Elderly
Crossroads Care Attendant Schemes
Development Team for the Mentally Handicapped
Disabled Living Foundation
Dr Barnado's
Elderly Invalids Fund
Environmental Health Officers Association
Exodus
Faculty of Community Medicine
Faculty of Dental Surgery
Family Forum
Family Practitioner Committees
Family Welfare Association
Federation of Alcoholic Rehabilitation Establishments
General Medical Services Committee of the BMA
General Nursing Council for England and Wales
General Synod of the Church of England: Board for Social Responsibility
General Whitley Council: Staff Side
Greater London Council
Guild of Health Education Officers
Health and Safety Executive
Health Visitors Association
Help the Aged
Hospital Caterers Association
Howard League for Penal Reform
Inner London Education Authority
Institute of Chartered Secretaries and Administrators
Institute of Child Psychology
Institute of Chiropodists
Institute of Health Service Administrators
Institute of Home Help Organisers
Institute of Management Services
Institute of Personnel Management
Institute of Purchasing and Supply
Institute of Statisticians
Institute for the Study of Drug Dependence
Jewish Welfare Board
Joint Consultants Committee
King Edward's Hospital Fund for London
Leonard Cheshire Foundation
London Borough Councils
London Boroughs Association
Maternity Alliance
Medical Commission on Child Accident Prevention
MENCAP
Medical Council on Alcoholism

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Medical Practices Committee
Mental After Care Association
Metropolitan County Councils
Metropolitan District Councils
MIND
Multiple Sclerosis Society
National Association for the Care and Resettlement of Offenders
National Association of Citizens Advice Bureaux
National Association of Health Authorities
National Association of Industrial Therapy Managers
National Association of Leagues of Hospital Friends
National Association for Maternal and Child Welfare
National Association of Theatre Nurses
National Association of Voluntary Help Organisers
National Association of Voluntary Hostels
National Association for the Welfare of Children in Hospital
National Board for Nursing Midwifery and Health Visiting
National Children's Bureau
National Children's Home
National Council on Alcoholism
National Council of Voluntary Child Care Organisations
National Council for Voluntary Organisations
National Cyrenians
National Federation of Housing Associations
National Foster Care Association
NHS Health Advisory Service
National Institute for Social Work
National Schizophrenia Fellowship
National Society for the Prevention of Cruelty to Children
National Youth Bureau
Non-Metropolitan County Councils
Non-Metropolitan District Councils
The Order of St John
Panel of Assessors for District Nurse Training
Panel of Four (Associations for the Deaf)
Regional Health Authorities
Release
The Residential Care Association
Richmond Fellowship for Mental Welfare and Rehabilitation
Royal Association for Disability and Rehabilitation
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Pathologists
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons
Royal National Institute for the Blind
Royal Society of Health
St Anne's Shelter and Housing Action Ltd
St John's Ambulance Brigade
Salvation Army Social Services
Save the Children Fund
Samaritans
Shelter, National Campaign for the Homeless
Social Welfare Commission

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Society of Chiropodists
Society of Family Practitioner Committees
Society of Hospital Laundry Managers
Society of Radiographers
Society of Remedial Gymnasts
Soroptomist International
Spastics Society
Standing Conference of Representatives of Health Visitor Training Centres
Standing Conference on Drug Abuse
Stonham Housing Association Ltd
TUC Health Services Committee
Turning Point
United Kingdom Central Council for Nursing Midwifery and Health Visiting
Voluntary Organisations Committee for IYDP
Voluntary Organisations Liaison Council for Children Under Five
Volunteer Centre
Women's Aid Federation
Women's Royal Voluntary Service

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